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Information Reporting Under the Affordable Care Act: I.R.C. §6055 and §6056

By Alden J. Bianchi, Esq.[1]

The Affordable Care Act (ACA) amends the Internal Revenue Code of 1986, as amended (I.R.C.), to include two new reporting requirements of particular interest to employers:

- Under §6055,[2] entities that offer minimum essential coverage (i.e., health insurance issuers, certain sponsors of self-insured plans, government agencies and other parties that provide health coverage) must report certain information about the coverage to the covered individual and the IRS relating to the enforcement of §36B; and
- Under §6056, applicable large employers (those with 50 or more full-time and full-time equivalent employees on average business days during the prior calendar year) must provide detailed information relating to their offer or failure to offer group health insurance under §4980H.

Both requirements take effect after December 31, 2014 — i.e., 2015 and later years. The §6055 and §6056 reporting requirements mirror the scheme used for the reporting of wages. A Form W-2, *Wage and Tax Statement*, is provided to each employee, and a copy of each such wage and tax statement is filed with the IRS using a transmittal form, i.e., Form W-3, *Transmittal of Wage and Tax Statements*. The comparisons to Forms W-2 and W-3 for purposes of §6055 and §6056 are IRS Forms 1094-B, *Transmittal of Health Coverage Information Returns*,[3] 1095-B, *Health Coverage*,[4] 1094-C, *Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns*,[5] and 1095-C, *Employer-Provided Health Insurance Offer and Coverage*,[6] respectively. The IRS has published final versions of these forms for 2014 along with instructions.[7]

Section 6055 and §6056 both require significant information about covered persons and the particular features of the group health plan coverage that they are offered. Required reports must be furnished to both the government and to covered individuals. Under §6055, minimum essential coverage providers must report to the IRS the persons to whom they provide minimum essential coverage and the months (or any part thereof) in which the coverage was provided. Self-funded group health plans must also furnish this

[1] Alden J. Bianchi, Esq. is a member of the law firm Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C. and serves as the practice group leader of the firm's Employee Benefits & Executive Compensation Practice.

[2] Unless otherwise identified, all ''section'' or ''§'' references herein are to the I.R.C.

[3] Available at http://www.irs.gov/pub/irs-pdf/f1094b.pdf.

[4] Available at http://www.irs.gov/pub/irs-pdf/f1095b.pdf.

[5] Available at http://www.irs.gov/pub/irs-pdf/f1094c.pdf.

[6] Available at http://www.irs.gov/pub/irs-pdf/f1095c.pdf.

[7] Available at http://www.irs.gov/pub/irs-pdf/i109495b.pdf (Forms 1094-B and 1095-B) (2014) and http://www.irs.gov/pub/irs-pdf/i109495c.pdf (Forms 1094-C and 1095-C) (2014).

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information to covered individuals along with contact information for the plan. Section 6056 requires applicable large employers to report to the IRS information about whether the company offered minimum essential coverage to full-time employees and their spouse and dependents; and, if so, the months during which coverage was available; the monthly cost to employees for the lowest self-only minimum essential coverage; the number of full-time employees during each month; and information about each full-time employee and the months they were covered under the plan.

The Treasury Department and IRS have issued final regulations under these rules.[8] In addition to substantive provisions, the final regulations establish rules governing the electronic delivery of employee statements[9] and electronic submission of employer transmittals.[10] Final versions of the necessary forms and instructions are also available.

1. INFORMATION REPORTING OF MINIMUM ESSENTIAL COVERAGE UNDER CODE §6055

Reg. §1.6055-1 establishes the general rule that:

> Every person that provides minimum essential coverage to an individual during a calendar year must file an information return and transmittal and furnish statements to responsible individuals on forms prescribed by the Internal Revenue Service.

Minimum essential coverage for this purpose is defined in §5000A(f) to mean health insurance coverage sufficient to avoid liability for tax under the ACA rules governing individual shared responsibility.[11] ''Minimum essential coverage'' includes coverage under Medicare Part A, Medicaid, the Children's Health Insurance Program (CHIP), TRICARE, the veteran's health care program, the Peace Corps program, a government plan (local, state, federal) including the Federal Employees Health Benefits Program (FEHBP), any plan established by an Indian tribal government, any plan offered in the individual, small group or large group market, a grandfathered health plan, and any other health benefits coverage designated by the Secretary of the Department of Health and Human Services (HHS) in coordination with the Secretary of Treasury Department, e.g., a state health benefits risk pool. Final regulations under §5000A clarify that coverage under a self-funded employer-sponsored group health plan may also qualify as minimum essential coverage.[12] This section of the article focuses on the obligations imposed on employers that sponsor self-funded group health plans under §6055.

(a) The Reporting Obligation

Section §7701(a) defines the ''person'' to mean and include ''an individual, a trust, estate, partnership, association, company or corporation.'' The final regulations refer to each person subject to the §6055 reporting rules as a ''reporting entity,'' i.e., ''any person that must report, under section 6055.''[13] Reporting entities that must file information return and transmittal forms generally include health insurance issuers, or carriers, for insured coverage,[14] plan sponsors of self-insured group health plan coverage, and the executive department or agency of a governmental unit that provides coverage under a government-sponsored program.[15] Reporting is not required, however, where coverage is provided through a public insurance exchange or marketplace.[16] Nor is reporting required for supplemental coverage where the primary and supplemental coverages have the same plan sponsor or in instances where the coverage supplements government-sponsored coverage, e.g., a Medicare supplement.[17] Reporting entities also include plan sponsors of self-insured group health plan coverage, the executive department or agency of a governmental unit that provides coverage under a government-sponsored self-funded plan, and any other person that provides minimum essential coverage.[18]

The plan sponsor of self-insured group health plan coverage is:

- The employer, in the case of a plan established or maintained by a single employer;
- The association, committee, joint board of trustees, in the case of a multiemployer plan;
- The employee organization for a union-sponsored self-insured group health plan;
- Each participating employer for a self-insured group health plan that is a Multiple Employer

[8] Reg. §1.6055-1, Reg. §301.6056-1.

[9] Reg. §1.6055-2, Reg. §301.6056-2.

[10] Reg. §301.6056-2.

[11] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, codified at 42 U.S.C. §18091 s. 1501.

[12] *See* Reg. §1.5000A-2(c)(1)(ii) (defining ''group health plan'' to include a ''self-insured group health plan under which coverage is offered by, or on behalf of, an employer to the employee'').

[13] Reg. §1.6055-1(b)(10).

[14] Reg. §1.6055-1(c)(1).

[15] Reg. §1.6055-1(c).

[16] Reg. §1.6055-1(d)(1).

[17] Reg. §1.6055-1(d)(2).

[18] Reg. §1.6055-1(c).

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Welfare Arrangement with respect to the participating employer's own employees; and

- For a self-insured group health plan or arrangement for which a plan sponsor is not otherwise identified above, the person designated by plan terms as the plan sponsor or plan administrator or, if no person is designated as the administrator and a plan sponsor cannot be identified, each entity that maintains the plan or arrangement.

The reporting obligations under §6055 apply only to individuals who enroll in coverage. There is no obligation to report offers of coverage to individuals who do not enroll.[19]

Reporting entities must provide information to each ''responsible individual.'' The term responsible individual means and includes:

> [A] primary insured, employee, former employee, uniformed services sponsor, parent, or other related person named on an application who enrolls one or more individuals, including him or herself, in minimum essential coverage.[20]

(b) Information Reported to the Government

Information returns filed under §6055 must include the following information for each calendar year of coverage:[21]

(i) The name, address, and employer identification number (EIN) of the reporting entity required to file the return;

(ii) The name, address, and Taxpayer Identification Number (TIN), or date of birth if a TIN is not available, of the responsible individual;

(iii) The name and TIN, or date of birth if a TIN is not available, of each individual who is covered under the policy or program;

(iv) For each covered individual, the months for which, for at least one day, the individual was enrolled in coverage and entitled to receive benefits; and

(v) Any other information specified in forms, instructions, or published guidance.

In addition, in the case of a fully-insured group health plan, the employer must also report the name, address, and EIN of the employer sponsoring the plan; whether the coverage is a qualified health plan enrolled in through the Small Business Health Options Program (SHOP) and the SHOP's unique identifier; and other information specified in forms, instructions, or other published guidance.[22]

In comments that followed the publication of both the proposed §6055 and §6056 regulations,[23] the requirement to report TINs generated a good deal of comment. Reg. §1.6055-1(e)(ii) and Reg. §1.6055-1(e)(iii) require, among other things, the reporting of a TIN ''or date of birth if a TIN is not available'' of the responsible individual and ''each individual who is covered under the policy or program,'' i.e., spouse and dependents. Failure to comply results in significant penalties (described below). Similar rules are set out in Reg. §301.6056-1(d)(viii). Commenters were uncertain about the amount of effort that might be required in gaining this information, particularly with respect to covered dependents. In response, the preamble to the final regulations points to Reg. §301.6724-1(e)[24] (relating to missing TINs) under which a person will be treated as acting in a responsible manner and penalties will be waived if the person properly solicits the TIN but does not receive it.[25] Under these rules, the reporting entity must make an initial solicitation at the time the relationship with the payee is established. If the reporting entity does not receive the TIN, it must make two additional annual solicitations. The first annual solicitation is generally required by December 31 of the year in which the relationship with the payee begins (January 31 of the following year if the relationship begins in December). Generally, if the TIN is still not provided, a second solicitation is required by December 31 of the following year. If a TIN is still not provided, the reporting entity has acted in a responsible manner and need not continue to solicit a TIN (and may comply by instead providing the individual's date of birth).

(c) Forms 1094-B and 1095-B and Accompanying Instructions

Health insurance issuers, sponsors of self-insured group health plans that are not applicable large employers, sponsors of multi-employer plans, and providers of government-sponsored coverage, report under §6055 on IRS Forms 1094-B and 1095-B. Applicable large employer members (see below) that

[19] Reg. §1.6055-1(d)(3).

[20] Reg. §1.6055-1(b)(11).

[21] Reg. §1.6055-1(e)(1).

[22] Reg. §1.6055-1(e)(2).

[23] *See* T.D. 9660, 79 Fed. Reg. 13,220, 13,223 (Mar. 10, 2014) (explaining what constitutes reasonable efforts to obtain TINs).

[24] Note that T.D. 9660 incorrectly cites to ''301.6724(e)'' instead of ''301.6724-1(e).''

[25] *Id.*

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provide coverage under a self-funded group medical plans are subject to the reporting requirements of both §6055 and §6056. Such employers are subject to a special rule intended to reduce duplication that combines the information required under §6055 and §6056 on Form 1095-C. An applicable large employer member that provides insured coverage will complete only those sections of Form 1095-C that report information required by §6056.

(i) Form 1094-B, Transmittal of Health Coverage Information Returns

Lines 1 through 8 provide the name and identifying information of the filer. Line 9 reports the ''[t]otal number of Forms 1095-B submitted with [the] transmittal.''

(ii) Form 1095-B, Health Coverage

Part I provides information about the ''Responsible Individual,'' i.e., plan participant, policyholder, etc. Indicator codes are used to identify the source of the coverage. For example, indicator code ''B'' identifies coverage under an employer-sponsored group health plan. Part II identifies the employer in instances where the coverage is employer-provided. Part III serves a similar purpose for other issuers or providers (e.g., individual market coverage purchased outside an exchange or marketplace). Part IV requires details on each covered individual, including his or her TIN (or his or her date of birth where a TIN is unavailable).

(d) Special Rules for Governmental Plans and Employers

The final regulations include a series of special rules related to governmental employers. Generally (i.e., in instances where there is no controlling statute or regulation), a government employer that maintains a self-insured group health plan is permitted to enter into a written agreement with another governmental unit, or an agency or instrumentality of a governmental unit, designating the other governmental unit, agency, or instrumentality as the person required to file the returns and to furnish the statements required by §6055.[26] Thus, for example, a political subdivision of a state may designate another political subdivision of the state.

Separate rules apply to Medicare and the Children's Health Insurance Program (CHIP), under which the state agency that administers these programs must file the returns and furnish the statements.[27] In the case of insured government-sponsored coverage, an executive department or agency of a governmental unit that provides coverage under a government-sponsored program such as Medicaid, CHIP, or Medicare (including Medicare Advantage), must file the returns and furnish the statements.[28]

(e) Time and Manner for Filing the Return

Each reporting entity must file the return and transmittal form required by Code §6055 on or before February 28 (March 31 if filed electronically) of the year following the calendar year in which it provided minimum essential coverage to an individual. Extensions of time are allowed under the rules that apply generally under Code §6081, which permits the government to ''grant a reasonable extension of time for filing any return, declaration, statement, or other document required by this title or by regulations.''[29]

(f) Statements Provided to Responsible Individuals

In addition to providing information to the government, Code §6055 and the final regulations impose on each person required to file a return an obligation to furnish each responsible individual with a statement that includes the information set out above.[30] In addition, the statement must show the phone number for a person designated as the reporting entity's contact person and policy number (if any). The statement may be made either by providing a copy of the Form 1095-B filed with the IRS or on a substitute statement that includes the information required to be shown on the Form 1095-B. Substitute forms are permitted, but the substitute must include all of the information required to be reported on Forms 1094-B and 1095-B, and they must comply with applicable revenue procedures or other published guidance relating to substitute statements.[31] Prior law establishes rules governing substitute forms.[32] In either case, the statement provided to the responsible individual may use a truncated taxpayer identification number in lieu of the identification number appearing on the corresponding information return.[33]

Reporting entities must furnish statements on or before January 31 of the year following the calendar

[26] Reg. §1.6055-1(c)(2)(ii).

[27] Reg. §1.6055-1(c)(3)(i).

[28] Reg. §1.6055-1(c)(3)(ii).

[29] Reg. §1.6081-1, Reg. §1.6081-8.

[30] Reg. §1.6055-1(g)(1).

[31] Reg. §1.6055-1(f)(2).

[32] *See* IRS Pub. 1167, *General Rules and Specifications for Substitute Forms and Schedules* (2015), available at http://www.irs.gov/pub/irs-pdf/p1167.pdf. This document incorporates Rev. Proc. 2015-18, 2015-8 I.R.B. 620.

[33] Reg. §1.6055-1(g)(3).

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year in which minimum essential coverage is provided, although extensions of time are available upon written application based on a showing of good cause.[34] Statements must be mailed to a responsible individual's last known permanent address or, if no permanent address is known, to the individual's temporary address.[35] Alternatively, statements may be furnished electronically if certain requirements are satisfied.[36] Generally, the recipient must have affirmatively consented to receive the statement in an electronic format. That recipient must also be able to withdraw his or her consent, and he or she must be advised of any changes in hardware or software requirements.[37]

(g) Penalties

In the case of information returns filed and furnished in 2016 for coverage provided in 2015 and later years, the §6721 penalty may apply to a provider that fails to file timely information returns, fails to include all the required information, or includes incorrect information on the return. The penalty under §6722 may apply to a provider that fails to furnish the statement in a timely manner, fails to include all the required information, or includes incorrect information on the statement. These rules are explained below.

2. INFORMATION REPORTING BY APPLICABLE LARGE EMPLOYERS

While the reporting rules under §6055 apply to a broad range of entities that provide minimum essential coverage, the rules under §6056 apply only to employers that are subject to §4980H, i.e., ''applicable large employers'' (ALE). A full-time employee generally includes any employee who was employed on average at least 30 hours of service per week and any full-time equivalents. While §4980H imposes assessable payments on applicable large employers in certain circumstances, the final regulations determine and impose such assessable payments on individual entities under common control, which the regulations refer to as ''applicable large employer members'' or ''ALE Members.'' An applicable large employer member is any person that is an applicable large employer or a member of an aggregated group (determined under §414(b), §414(c), §414(m) or §414(o)) that is determined to be an applicable large employer.[38]

Government entities, churches, and a convention or association of churches must use the same interpretation of controlled group rules that apply under §4980H in determining whether a person or group of persons is an applicable large employer and whether a particular entity is an applicable large employer member.[39] These entities are permitted to ''apply a reasonable, good faith interpretation of §414(b), §414(c), §414(m) and §414(o)'' in determining their status as an applicable large employer.[40]

Originally slated to take effect in 2014, the effective date of the §6055 and §6056 reporting requirements were delayed until January 1, 2015.[41]

(a) The Basic Reporting Rule

The final regulations under §6056 state the basic rule as follows:

> Section 6056 requires an applicable large employer subject to the requirements of section 4980H to report certain health insurance coverage information to the Internal Revenue Service, and to furnish certain related employee statements to its full-time employees.[42]

Each applicable large employer member must make a return (under its own employer identification number) and furnish a related statement to its full-time employees for each calendar year. Returns must be filed on or before February 28 (March 31 if filed electronically) of the year succeeding the calendar year to which it relates.[43] The first returns will be due in early 2016. An applicable large employer member may enter into a reporting arrangement with a third-party administrator, but such an arrangement does not absolve the applicable large employer member from potential liability under §6056. (A different rule applies in the case of governmental units, described below).

An applicable large employer member must report information about the health coverage, if any, offered to its full-time employees, *including whether an offer of health coverage was (or was not) made*. This

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[34] Reg. §1.6055-1(g)(4)(i)(B)(1).

[35] Reg. §1.6055-1(g)(4)(ii).

[36] Reg. §1.6055-2 establishes rules for the electronic furnishing of statements.

[37] Reg. §1.6055-2(a)(2).

[38] The Instructions for IRS Forms 1094-C and 1095-C (discussed below) alternatively and confusingly refer to the term applicable large employer as an ''Aggregated ALE Group,'' i.e., the controlled group that comprises an applicable large employer.

[39] T.D. 9661, 79 Fed. Reg. 13,231, 13,234, §VIII (Mar. 10, 2014).

[40] T.D. 9655, 79 Fed. Reg. 8,543, 8,548 (Feb. 12, 2014).

[41] Notice 2013-45, 2013-31 I.R.B. 116.

[42] Reg. §301.6056-1(a).

[43] Reg. §301.6056-1(e).

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means that an applicable large employer member that employs full-time employees but offers no group health plan coverage is nevertheless required to file a return with the IRS and furnish a statement to the employee reporting that coverage was not offered. Employers that are not subject to the employer shared responsibility provisions of §4980H are not required to report under §6056. Thus, employers that employed fewer than 50 full-time employees (including full-time equivalents) during the prior year are not subject to the reporting requirements. But if such an employer sponsors a self-insured group health plan, reporting is nevertheless required under §6055.

The following table summarizes the particulars of the §6055 and §6056 reporting obligations as applied to employers:

ALE or Non-ALE Member?	*Type of Minimum Essential Coverage (MEC)*	*Form 1095-B*	*Form 1095-C*
ALE Member	Self-funded MEC	None	Provide to all covered individuals, all part-time employees offered coverage, and all full-time employees. Complete Part III for all covered individuals (i.e. full-time, part-time and dependents who are enrolled in the MEC). Complete parts I and II for full-time employees (whether or not offered coverage) and for all part-time employees offered coverage. For part-time employees offered coverage, enter code ''1G'' on Line 14 of Part II. **Do not provide to part-time employees who are not offered coverage.**
ALE Member	Insured MEC	Insurer provides to all covered individuals (including part-time).	Provide with Parts I and II completed to full-time employees only.
ALE Member	No MEC	None	Provide with Parts I and II completed to full-time employees only.
Non-ALE Member	Self-funded MEC	Employer provides to all covered individuals (including part-time).	None
Non-ALE Member	Insured MEC	Insurer provides to all covered individuals (including part-time).	None
Non-ALE Member	No MEC	None	None

(b) Information Required to Be Reported

Each information return under §6056 must include:[44]

(i) The name, address, and employer identification number of the applicable large employer member;

(ii) The name and telephone number of the applicable large employer's contact person;

(iii) The calendar year for which the information is reported;

(iv) A certification as to whether the applicable large employer member offered to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan, by calendar month;

(v) The months during the calendar year for which coverage under the plan was available;

(vi) Each full-time employee's share of the lowest cost monthly premium (self-only) for coverage providing minimum value offered to that full-time employee under an eligible employer-sponsored plan, by calendar month;

(vii) The number of full-time employees for each month during the calendar year; and

(viii) The name, address, and taxpayer identification number of each full-time employee during the calendar year; and the months, if any, during which the employee was covered under the plan.

Consistent with earlier proposed regulations, the final regulations do not require reporting of the length of any permissible waiting period, the employer's share of the total allowed costs of benefits under the plan or the monthly premium for the lowest-cost op-

[44] Reg. §301.6056-1(d).

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tion *in each enrollment category* under the plan (e.g., self-only coverage).[45]

(c) Forms 1094-C and 1095-C and Accompanying Instructions

Each applicable large employer member must file one or more Forms 1094-C (including a Form 1094-C designated as the Authoritative Transmittal, whether or not filing multiple Forms 1094-C), and must file a Form 1095-C (or a substitute form) for each employee who was a full-time employee of the employer for any month of the calendar year. An employee in a ''Limited Non-Assessment Period,'' i.e., a period during which an ALE Member will not be subject to an assessable payment under §4980H[46] — is not considered a full-time employee regardless of whether that employee is offered health coverage during that period. The instructions clarify that an employer that offers self-funded health coverage to non-employees who enroll in the coverage (e.g., non-employee directors, an individual who is a retired employee during the entire year, or a non-employee COBRA beneficiary) may use Forms 1094-B and 1095-B, rather than Form 1095-C, Part III, to report coverage for those individuals and other family members. But self-funded health coverage provided to a retiree who was active during a portion of the year is reported on Form 1095-C, Part III.

The Instructions were less than clear about reporting mid-year offers of COBRA coverage, whether in the case of a terminating employee or in the case of an employee who reduces hours resulting in the loss of eligibility. The matter was subsequently clarified in a set of IRS-issued questions and answers[47] that require the employer to report what coverage is actually elected in the case of a terminating employee. This approach differs from the basic reporting rule under which the offer of coverage code (line 14) is based generally on the plan's eligibility rules. While the IRS did not articulate a reason for this difference, it appears to be rooted in the way in which COBRA coverage is treated under Prop. Reg. §1.36B-2(c)(3)(iv),[48] which reads:

> A former employee who may enroll in continuation coverage required under Federal law or a State law that provides comparable continuation coverage, and an individual who may enroll in retiree coverage under an eligible employer-sponsored plan, are eligible for minimum essential coverage under this coverage *only for months that the individual is enrolled in the coverage*. (Emphasis added).

Thus, while an active employee may be rendered ineligible for premium subsidies — or ''firewalled'' — based on an offer of coverage that is both affordable and provides minimum value, a COBRA qualified beneficiary may be firewalled based only on actual enrollment.

Only one Form 1095-C is filed for employment with each ALE member. Thus, for example, if an employer separately reports for each of its two divisions, the employer must combine the offer and coverage information for any employee who worked at both divisions on a single Form 1095-C. But a full-time employee who works for more than one employer that is a member of the same ALE must generally receive a separate Form 1095-C from each ALE member. If an employee works for two or more ALE members in the same calendar month, only one ALE member will report that employee for the month.

The information required to be reported under §6056 is included on Forms 1094-C and 1095-C. Substitute forms are permitted, but the substitute must include *all* of the information required to be reported on Forms 1094-C and 1095-C, and they must comply with applicable revenue procedures or other published guidance relating to substitute statements.[49] Prior law establishes rules governing substitute forms.[50]

(i) Form 1094-C, Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

While nominally designated and functioning as a ''transmittal'' form, Form 1094-C is also a source of detailed information about the employer/plan sponsor including total employee count, information about ALE members, and qualifying offers, among others items. Part I identifies the ALE member submitting the return. Part II solicits information about the ALE member. Part II also asks whether the filing is the authoritative transmittal, and if so, asks about the total number of Forms 1095-C being filed. It also asks about qualifying offers and transition relief. Part III reports detailed information about offers of coverage,

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[45] 79 Fed. Reg. 13,231, 13,236–13,237 (Mar. 10, 2014).

[46] Reg. §54.4980H-1(a)(26).

[47] ''Questions and Answers about Employer Information Reporting on Form 1094-C and Form 1095-C,'' available at http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-about-Employer-Information-Reporting-on-Form-1094-C-and-Form-1095-C, Q&As -16, -17 and -18.

[48] REG-125398-12, 78 Fed. Reg. 25,909 (May 3, 2013), proposed to apply for taxable years ending after December 31, 2013. Taxpayers may apply the proposed rule for taxable years ending before January 1, 2015.

[49] Reg. §301.6056-1(d)(2).

[50] IRS Publication 1167, *General Rules and Specifications for Substitute Forms and Schedules* (2015), available at http://www.irs.gov/pub/irs-pdf/p1167.pdf.

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month-by-month. Lastly, Part IV identifies all other members of the ALE (where there are more than 30 such members, only the 30 with the largest number of full-time employees must be disclosed).

An employer offers health coverage for a month only if it offers health coverage that would provide coverage for every day of that calendar month. For purposes of completing Form 1094-C, an offer of coverage does not occur for a month if an employee's employment terminates before the last day of a calendar month *and* the health coverage also ends before the last day of that calendar month (or for an employee who didn't enroll in coverage, the coverage would have ended if the employee had enrolled in coverage). However, where an employee terminates employment mid-month, the employer may be treated for §4980H purposes as having offered coverage for the entire month.[51] The IRS is alerted to mid-month terminations on Form 1094-C by the use of an indicator code.

For any month in which an employee was an employee, he or she is included in the total employee count reported on Form 1094-C, Part III. The final regulations under §4980H provide that an employee's status is determined using the common-law standard.[52] While the proper classification of employees has always been important, §4980H and §6056 increase the stakes.[53]

(ii) Form 1095-C (Employer-Provided Health Insurance Offer and Coverage)

Part I identifies the employee to whom the form is being provided. Part II reports offers of coverage. Part II, Line 14 reports offers of coverage for §36B purposes, using a series of letter indicator codes. Line 15 reports the employee share of the lowest cost monthly premium for self-only, minimum value coverage. Line 16 reports safe harbors for §4980H purposes. Thus, for example, there might be no offer of coverage during a waiting period, so the employee might have access to a subsidy under §36B, but because the waiting period is a ''non-assessment'' period, there is no §4980H exposure. Part III applies only to self-funded plans, and it identifies covered individuals and the months in which they were covered.

No Form 1095-C is required for an individual who, for each month of a calendar year, is not an employee, or who is an employee but is in a limited non-assessment period (e.g., a variable hour employee in his or her initial measurement period). If, however, an employee in a limited non-assessment period is enrolled in coverage under a self-funded employer-sponsored plan, a Form 1095-C is required.

(d) Reporting for §4980H Transition Relief

The preamble to the final §4980H regulations establish a series of transition rules, many of which require employers to certify their eligibility. Compliance with the applicable certification requirements is reported in Parts II and III of Form 1094-C.

(i) Transition Relief for 50-99 Full Time Employees

An employer with 50 to 99 full-time employees, including full-time equivalent employees, in 2014 has no §4980H exposure for 2015 or for the plan year commencing in 2015 if:

- The employer is an ALE or is part of an Aggregated ALE Group that had 50 to 99 full-time employees, including full-time equivalent employees, in 2014;
- During the period of February 9, 2014, through December 31, 2014, the ALE or the Aggregated ALE Group of which the employer is a member did not reduce the size of its workforce or reduce the overall hours of service of its employees in order to qualify for the transition relief; and
- During the period of February 9, 2014, through December 31, 2015 (or, if the employer has a non-calendar-year plan, the last day of the 2015 plan year) the ALE or Aggregated ALE Group of which the employer is a member does not eliminate or materially reduce the health coverage, if any, it offered as of February 9, 2014.

(ii) Transition Relief for 100 or More Full Time Employees

For each month in 2015 (and, in addition, for the portion of the 2015 plan year that ends in 2016 if the employer has a non-calendar year plan), if an employer is an ALE or is part of an Aggregated ALE Group that had 100 or more full-time employees (including full-time equivalent employees) in 2014, and is subject to an assessable payment under §4980H(a), the assessable payment under §4980H(a) is calculated

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[51] *See* Reg. §54.4980H-4(c) (providing that ''in a calendar month in which the employment of a full-time employee terminates, if the employee would have been offered coverage for the entire calendar month had the employee been employed for the entire calendar month, the employee is treated as having been offered coverage for that entire calendar month'').

[52] Reg. §54.4980H-1(a)(15). *See* Reg. §31.3401(c)-1(b) (setting out the standards for common law employee determinations). For Reg. §54.4980H-1(a)(15) purposes, a leased employee, a sole proprietor, a partner in a partnership, a 2% S corporation shareholder, or a worker described in §3508 is not an employee.

[53] Bianchi & Lenz, *The Final Code §4980H Regulations; Common Law Employees; and Offers of Coverage by Unrelated Employers*, 55 Tax Mgmt. Memo. 331 (2014).

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by reducing the employer's number of full-time employees by that employer's allocable share of 80 (rather than by the employer's standard allocable share of 30). Eligibility for this transition relief is reported on Form 1094-C, line 22, Box c and lines 23 to 35, Column (e).

(iii) 70 Percent Offer Transition Relief

For each calendar month during 2015 (and any calendar months during the 2015 plan year that occur in 2016, if the employer has a non-calendar year plan), an employer that offers health coverage to at least 70% (rather than 95%) of its full-time employees (and their dependents) is not subject to penalties under §4980H(a). Eligibility for this transition relief is reported on Form 1094-C, lines 23 to 35, Column (a).

(iv) Dependent Coverage Transition Relief

For the 2014 and 2015 plan years, for an employee who was not offered dependent health coverage during the 2013 or 2014 plan years, an employer may treat an offer of health coverage to a full-time employee but not his or her dependents, as an offer of health coverage to the full-time employee and his or her dependents, if the employer takes steps during the 2014 or 2015 plan year (or both) to extend coverage under the plan to dependents not offered coverage during the 2013 or 2014 plan year (or both). Note however, that an employer using this transition relief may not also use the Qualifying Offer Method (or the Qualifying Offer Transition Relief Method) for that calendar year. Eligibility for this transition relief is reported on Form 1094-C, lines 23 to 35, Column (a).

(v) Non-calendar Year Plan Transition Relief

An employer that sponsored a non-calendar year health plan as of December 27, 2012 may be eligible for transition relief that postpones §4980H compliance until the first day of the non-calendar plan year commencing in 2015 if certain conditions are satisfied. Where the following requirements are satisfied, no penalty under §4980H(a) will be imposed:

- For an employee (whenever hired) who was eligible for health coverage under that non-calendar year health plan effective beginning on the first day of the 2015 plan year under the eligibility terms of the plan as in effect on February 9, 2014, the employer may treat the employee (and his or her dependents) as having been offered coverage for the months in 2015 prior to the 2015 plan year if the employee was offered health coverage no later than the first day of the 2015 plan year.
- If an employer had at least 25% of all its employees (full-time and non-full-time) enrolled in health coverage under the non-calendar year plan as of any date in the 12 months ending on February 9, 2014, or offered health coverage under the non-calendar year plan to at least 33% of all its employees during the open enrollment period that ended most recently before February 9, 2014, then the employer may treat an employee who was not offered coverage for the months in 2015 prior to the 2015 plan year (and his or her dependents) as having been offered coverage for that period if the employee was offered health coverage no later than the first day of the 2015 plan year.
- If an employer had at least 33% of its full-time employees enrolled in health coverage under the non-calendar year plan as of any date in the 12 months ending on February 9, 2014, or offered health coverage under the non-calendar year plan to at least 50% of its full-time employees during the open enrollment period that ended most recently before February 9, 2014, then the employer may treat an employee who was not offered coverage for the months in 2015 prior to the 2015 plan year (and his or her dependents) as having been offered coverage for that period if the employee was offered health coverage no later than the first day of the 2015 plan year.

In addition, relief is also provided for §4980H(b) purposes if the coverage offered to the employee by the beginning of the 2015 plan is affordable and provides minimum value. In this latter case, the employee may be treated for purposes of §4980H(b) as offered minimum essential coverage providing minimum value that is affordable for the months prior to the beginning of the 2015 plan year. An employer that meets these requirements reports its eligibility on the Form 1095-C with the use of a designated code.

(vi) January 2015 Transition Relief

Solely for January 2015, if an employer offers health coverage to an employee no later than the first day of the first payroll period that begins in January 2015, the employer is treated as having offered health coverage for January 2015.

This transition relief is reported on Form 1094-C, lines 23 to 35, Column (a) and on Form 1095-C, line 14.

(c) Rules Governing "Governmental Units"

Similar to the §6055 reporting rules, the final §6056 regulations include a series of special rules related to governmental employers, which are referred to as ''governmental units.'' A governmental unit is defined as ''the government of the United States, any State or political subdivision thereof, or any Indian tribal gov-

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ernment (as defined in §7701(a)(40)) or subdivision of an Indian tribal government (as defined in §7871(d)).''[54] Each governmental unit may report on its behalf or may appropriately designate another person or persons to do so, provided the designation is in writing and the designee is part of or related to the same governmental unit.[55] An appropriately designated entity is subject to the information reporting penalty provisions of §6721 and §6722 explained below.

(d) Reporting Methods

The final regulations provide a ''general method'' and two optional reporting methods that applicable large employer members may use for §6056 purposes. If an applicable large employer member does not qualify for the alternative reporting methods, it must use the general method. Certain information required to be reported to the IRS and furnished to full-time employees may be reported through the use of indicator codes rather than by providing more detailed information.

(i) General Method

An applicable large employer member may satisfy §6056 by filing a Form 1094-C (transmittal) and, for each full-time employee, a Form 1095-C (employee statement), or other forms the IRS may designate. An applicable large employer that maintains a self-insured plan also uses a Form 1095-C to satisfy the reporting requirements under §6055. In contrast, nonapplicable large employer members (i.e., employers who are not subject to the employer shared responsibility provisions) that sponsor self-insured plans will file Forms 1094-B and 1095-B to satisfy the reporting requirements under §6055. Under the general method, the §6056 return (and, if the employer maintains a self-insured plan, the §6055 return) also may be made by filing a substitute form but the substitute form must include all of the information required on Forms 1094-C and 1095-C, or any other forms the IRS designates, and satisfy all form and content requirements as specified by the IRS.

(ii) Alternative Reporting Methods

The regulations contain two alternative reporting methods that permit an applicable large employer member to provide less detailed information than under the general method for reporting. These simplified alternative reporting methods and the conditions for using them are described below. The alternative reporting methods are:

- Reporting Based on Certification of Qualifying Offers (Qualifying Offer Method)

To be eligible to use the Qualifying Offer Method, the employer must certify that it made a Qualifying Offer to one or more of its full-time employees for all months during the year in which the employee was a full-time employee for whom an employer shared responsibility payment could apply. A ''qualifying offer'' is defined as:

> [A]n offer of minimum essential coverage providing minimum value to one or more full-time employees for all calendar months during the calendar year for which the employee was a full-time employee for whom a section 4980H assessable payment could apply, at an employee cost for employee-only coverage for each month not exceeding 9.5 percent of the mainland single federal poverty line divided by 12, provided that the offer includes an offer of MEC to the employee's spouse and dependents (if any).

The Qualifying Offer Method is optional. An employer that qualifies for and applies this approach does not need to report the lowest cost monthly premium for self-only coverage. Instead, the employer simply uses a code to indicate that the employee received a Qualifying Offer for all 12 months. Where an employee does not receive a Qualifying Offer for all 12 months, the employer remains eligible to use the Qualifying Offer Method for any month for which it made a Qualifying Offer to an employee. In this latter case, the employer must furnish a copy of Form 1095-C to the employee unless the Qualifying Offer Method Transition Relief (described below) applies.

An employer that is eligible to use the Qualifying Offer Method meets the requirement to furnish the Form 1095-C to its full-time employees who received a Qualifying Offer for all 12 months of the calendar year, and who did not enroll in coverage that is self-insured coverage, if it furnishes each of those full-time employees either a copy of Form 1095-C as filed with the IRS or a statement containing the employer's name, address, and EIN, a contact name and telephone number at which the employee may receive further information, a statement indicating that, for all 12 months of the calendar year, the employee and his or her spouse and dependents, if any, received a Qualifying Offer and therefore are not eligible for a premium tax credit, and a statement directing the employee to see IRS Publication 974, *Premium Tax Credits*. But for a full-time employee who received a Qualifying Offer and enrolled in self-insured coverage, the employer must furnish the information re-

[54] Reg. §301.6056-1(b)(7).

[55] 79 Fed. Reg. 13,231 at 13,245 (Mar. 10, 2014).

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porting enrollment in the coverage on Form 1095-C, Part III and the employer may not use the alternative method of furnishing Form 1095-C under the Qualifying Offer Method for that employee.

- 2015 Qualifying Offer Method Transition Relief

An optional transition rule is available in 2015 in the case of employers making a Qualifying Offer for one or more months of calendar year 2015 to at least 95% of their full-time employees, without regard to any employee in a Limited Non-Assessment Period. Under this rule, an employer does not report the cost of the lowest cost monthly premium for self-only coverage and instead applies an indicator code. As with the general Qualifying Offer Method, the employer that sponsors a fully-insured plan may provide a substitute statement to full-time employees who received a Qualifying Offer for all 12 months of 2015. In addition, solely for 2015, the employer, in lieu of providing the employee with a copy of Form 1095-C, may furnish a substitute statement to any employee who does not receive a Qualifying Offer for all 12 calendar months, including employees who receive no offer. What distinguishes this method from the general Qualifying Offer Method is that it may be used by an employer that makes a Qualifying Offer for some but not all 12 months of the year.

- Option to Report Without Separate Identification of Full-Time Employees if Certain Conditions Related to Offers of Coverage Are Satisfied (98% Offers)

To be eligible to use the 98 Percent Offer Method, an employer must certify that it offered, for all months of the calendar year, affordable health coverage providing minimum value to at least 98% of its employees for whom it is filing a Form 1095-C employee statement, and offered minimum essential coverage to those employees' dependents. The benefit to the employer is that there is no requirement to identify which of the employees for whom it is filing were full-time employees. The employer must nevertheless file Forms 1095-C on behalf of all of its full-time employees.

(e) Electronic Filing of Returns

An applicable large employer member is generally required to file the information return under §6056 electronically.[56] There is an exception that applies in the case of ''low-volume filers'' who are permitted to file on the prescribed paper form. A low-volume filer is an ALE member that is required to file fewer than 250 returns during the calendar year.[57] Each §6056 information return for a full-time employee is a separate return.

(f) Electronic Furnishing of Statements

The rules described above relating to the electronic furnishing of statements for §6055 have a parallel in the final regulations under §6056. Reg. §301.6056–2 allows an applicable large employer member to furnish statements to a full-time employee in an electronic format in lieu of a paper format, provided that the employer meets certain requirements.

(g) Penalties

The penalties imposed on an applicable large employer member that fails to file timely information returns, fails to include all the required information, or includes incorrect information on the returns are those prescribed by §6721 and §6722.[58]

Section 6721 imposes a penalty for any failure to file an information return by the required filing date, any failure to include all information required to be shown on the return, and any inclusion of incorrect information on the return. The penalty is paid on notice and demand in the same manner as a tax.[59] The amount of the penalty is generally $100 for each affected return, but it can be reduced to as low as $30 depending on whether, and how soon the failure is corrected. A higher penalty of $250 can apply in the case of intentional disregard of the filing requirements.[60]

Section 6722 imposes a penalty for failure to furnish a payee statement on or before the prescribed date and for failure to include all the required information on the statement or the inclusion of incorrect information. The §6722 penalty is generally $100, but, as is the case with the penalty under §6721, it can be reduced if it is timely corrected, and increased in cases of intentional disregard. Penalties under §6721 and §6722 may be abated if the failure to file or the failure to furnish a payee statement was due to reasonable cause and not willful neglect.[61]

The preamble to the final regulations clarifies that for a limited time the IRS will not impose penalties under §6721 and §6722 on applicable large employer

[56] Reg. §301.6056-1(e), referencing Reg. §301.6011-2(c).

[57] *Id.*

[58] Reg. §1.6055-1(h).

[59] §6724(b).

[60] §6721(e)(2).

[61] §6724(a).

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members that can show that they have made good faith efforts to comply with the information reporting requirements.[62] Specifically, relief is provided from penalties for returns and statements filed and furnished in 2016 to report offers of coverage in 2015 for incorrect or incomplete information reported on the return or statement. No relief is provided in the case of applicable large employer members that cannot show a good faith effort to comply with the information reporting requirements or who fail to timely file an information return or furnish a statement. Nevertheless, applicable large employer members that fail to timely meet the requirements still may be eligible for penalty relief if the IRS determines that the standards for reasonable cause under §6724 are satisfied.

(h) Reporting by Multiemployer Plans

Applicable large employer members that are required by the terms of one or more collective bargaining agreements to contribute to multiemployer plans face at least two unique challenges: first, eligibility to participate in the plan is determined by the terms of the plan over which the employer has no control; second, the employer lacks access to the basic information required to comply with the §6056 reporting requirements. The preamble to the final §4980H regulations includes a special rule under which an employer is treated as offering health coverage to an employee if the employer is required by a collective bargaining agreement or related participation agreement to make contributions for that employee to a multiemployer plan that offers, *to individuals who satisfy the plan's eligibility conditions*, health coverage that is affordable and provides minimum value, and that also offers health coverage to those individuals' dependents or is eligible for the §4980H transition relief regarding offers of coverage to dependents. This rule is significant because the employer is not required to discern whether any particular employee was actually offered coverage or concern itself with the multiemployer plan's eligibility conditions. The employer need only contribute at the times and in the amounts dictated by the agreement. (This relief also carries over to the §6055 reporting requirements.)[63]

The plan administrator of a multiemployer plan must prepare returns pertaining to the applicable large employer member's full-time employees covered by the collective bargaining agreement who are eligible to participate in the multiemployer plan. (The applicable large employer member must still prepare returns pertaining to any of its full-time employees who are not eligible to participate in a multiemployer plan.) The administrator of the multi-employer plan also may assist the applicable large employer members to furnish statements to its full-time employees who are eligible to participate in the plan. Nevertheless, the applicable large employer member remains the responsible person for reporting under §6056 for *all* of its full-time employees.

The special rule that applies to multi-employer plans does not relieve the applicable large employer member from any penalties resulting from the failure to offer coverage that is affordable and provides minimum value. But an applicable large employer member that takes advantage of the rule is treated as having made an offer of coverage to all full-time employees covered by the collective bargaining agreement for §4980H purposes irrespective of whether the employee is actually qualifies for coverage.

3. CONCLUSION

Section 6055 and §6056 impose requirements that are granular, prescriptive, and burdensome. While there is some disagreement as to whether the regulators could have provided rules that were simpler, there is little doubt that the regulations did not accomplish this goal. As a result, the regulations too are granular, prescriptive, and burdensome.

The compliance challenges posed by §6055 and §6056 are high. While a number of vendors have developed software solutions to assist employers to meet their reporting obligations, these solutions are either currently untested or in early, beta-testing stages. Recognizing the difficulties that employers face as they endeavor to comply, the IRS has announced that it will not impose penalties on employers ''that can show that they have made good faith efforts to comply with the information reporting requirements.''[64] The relief applies to returns and statements filed and furnished for 2015. No relief is available under this rule, however, for employers that fail to timely file an information return or furnish a statement. While other relief may be available under the general standards for reasonable cause described above, it behooves employers to take steps now to be ready to comply next year.

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[62] 79 Fed. Reg. 13,231 at 13,246 (Mar. 10, 2014).

[63] 79 Fed. Reg. 13,231, 13,245 (Mar. 10, 2014).

[64] 79 Fed. Reg. 13,220, 13,226 (Mar. 10, 2014); 79 Fed. Reg. 13,231, 13,246 (Mar. 10, 2014).

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